(3) Upon request, physician incentive plans as set forth in § 438.6(h).

(i) *Special rules: States with mandatory enrollment under State plan authority*—(1) *Basic rule.* If the State plan provides for mandatory enrollment under § 438.50, the State or its contracted representative must provide information on MCOs and PCCMs (as specified in paragraph (i)(3) of this section), either directly or through the MCO or PCCM.

(2) *When and how the information must be furnished.* The information must be furnished as follows:

(i) For potential enrollees, within the timeframe specified in § 438.10(e)(1).

(ii) For enrollees, annually and upon request.

(iii) In a comparative, chart-like format.

(3) *Required information.* Some of the information is the same as the information required for potential enrollees under paragraph (e) of this section and for enrollees under paragraph (f) of this section. However, all of the information in this paragraph is subject to the timeframe and format requirements of paragraph (i)(2) of this section, and includes the following for each contracting MCO or PCCM in the potential enrollees and enrollee's service area:

(i) The MCO's or PCCM's service area.

(ii) The benefits covered under the contract.

(iii) Any cost sharing imposed by the MCO or PCCM.

(iv) To the extent available, quality and performance indicators, including enrollee satisfaction.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§ 438.12 Provider discrimination prohibited.

(a) *General rules.* (1) An MCO, PIHP, or PAHP may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If an MCO, PIHP, or PAHP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision.

(2) In all contracts with health care professionals, an MCO, PIHP, or PAHP must comply with the requirements specified in § 438.214.

(b) *Construction.* Paragraph (a) of this section may not be construed to—

(1) Require the MCO, PIHP, or PAHP to contract with providers beyond the number necessary to meet the needs of its enrollees;

(2) Preclude the MCO, PIHP, or PAHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

(3) Preclude the MCO, PIHP, or PAHP from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

Subpart B—State Responsibilities

§ 438.50 State Plan requirements.

(a) *General rule.* A State plan that requires Medicaid beneficiaries to enroll in managed care entities must comply with the provisions of this section, except when the State imposes the requirement—

(1) As part of a demonstration project under section 1115 of the Act; or

(2) Under a waiver granted under section 1915(b) of the Act.

(b) *State plan information.* The plan must specify—

(1) The types of entities with which the State contracts;

(2) The payment method it uses (for example, whether fee-for-service or capitation);

(3) Whether it contracts on a comprehensive risk basis; and

(4) The process the State uses to involve the public in both design and initial implementation of the program and the methods it uses to ensure ongoing public involvement once the State plan has been implemented.

(c) *State plan assurances.* The plan must provide assurances that the State meets applicable requirements of the following statute and regulations:

(1) Section 1903(m) of the Act, for MCOs and MCO contracts.

(2) Section 1905(t) of the Act, for PCCMs and PCCM contracts.